



PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

| | |
|----------------------------|-----------------------------|
| Patient Name: _____ | Date of Birth: _____ |
|----------------------------|-----------------------------|

I authorize Grand Peaks facilities to release information to: myself my authorized representative
 Other Provider or healthcare _____
 Address: _____ Phone #: _____ Fax#: _____

I authorize another provider/office:
 Provider/Office Name _____
 Address: _____ Phone #: _____ Fax#: _____

To release medical records to the following Grand Peaks location:

| | | |
|--------------------------|--|---------------------|
| MEDICAL | | |
| <input type="checkbox"/> | 335 E Main St, STE 1 St. Anthony, ID 83445 | Fax# (208) 624-4116 |
| <input type="checkbox"/> | 72 S 1st E, Ste 101 Rexburg, ID 83440-1902 | Fax# (208) 356-3724 |
| <input type="checkbox"/> | 2454 N 25th E, STE 101 Idaho Falls, ID 83401 | Fax# (208) 612-6118 |

| | | |
|--------------------------|--|---------------------|
| BEHAVIORAL HEALTH | | |
| <input type="checkbox"/> | 335 E Main St, STE 3 St. Anthony, ID 83445 | Fax# (208) 624-4030 |
| <input type="checkbox"/> | 72 S 1st E, Ste 103 Rexburg, ID 83440-1902 | Fax# (208) 372-1023 |
| <input type="checkbox"/> | 2454 N 25th E, STE 102 Idaho Falls, ID 83401 | Fax# (208) 612-6118 |

| | | |
|--------------------------|--|---------------------|
| DENTAL | | |
| <input type="checkbox"/> | 325 E Main St St. Anthony, ID 83445 | Fax# (208) 624-4117 |
| <input type="checkbox"/> | 72 S 1st E, Ste 102 Rexburg, ID 83440-1902 | Fax# (208) 359-1600 |
| <input type="checkbox"/> | 2454 N 25th E, STE 201 Idaho Falls, ID 83401 | Fax# (208) 612-6123 |

| | | |
|--------------------------|---|---------------------|
| PHARMACY | | |
| <input type="checkbox"/> | 335 E Main St, STE 4 St. Anthony, ID 83445 Ph# (208) 624-8300 | Fax# (208) 624-4114 |
| <input type="checkbox"/> | 72 S 1st E, Ste 104 Rexburg, ID 83440-1902 Ph# (208) 372-8300 | Fax# (208) 372-4114 |
| <input type="checkbox"/> | 2454 N 25th E, STE 103 Idaho Falls, ID 83401 Ph# (208) 612-6300 | Fax# (208) 612-6119 |

Medical record information to be released:
 Entire medical record including patient healthcare history, office notes (except psychotherapy notes), test results, radiology studies, referrals, consultations, billing records, insurance records and records sent by other healthcare providers.
 Medical records from (Date) _____ to (Date) _____
 Description of information to be released: _____
 For the purpose of: Continuation of treatment Personal Other _____

TO BE READ AND SIGNED BY THE PATIENT:

- I UNDERSTAND THE FOLLOWING:
- This authorization expires 1 year from the date signed unless terminated in writing.
 - I may revoke this authorization at any time by providing written notice to Grand Peaks.
 - I may not be able to revoke this authorization if Grand Peaks has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
 - I understand that if I refuse to sign this disclosure, it will not affect my ability to obtain treatment.
 - I understand that I may inspect or copy any information to be used or disclosed under this authorization.
 - I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by federal privacy laws or regulations.
 - I understand federal regulations require a description of how much and what kind of information is to be disclosed. Information relating to drug and alcohol abuse, confidential HIV related information and mental health treatment (except psychotherapy notes) will only be disclosed if stated above in the description.
 - Please allow 30 business days for records to be prepared. *There may be a charge for these services.*

| | | |
|---|--------------|------|
| Patient/Authorized Representative Signature | Printed Name | Date |
| Relationship to Patient: _____ | | |